CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155131		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			CON	(X3) DATE SURVEY COMPLETED 06/01/2011	
	PROVIDER OR SUPPLIER			7935 C	ADDRESS, CITY, STATE, ZIP CO ALUMET AVENUE ER, IN46321	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F0000	Complaint IN000 deficiencies relaticited. Complaint IN000 deficiencies relaticited. Complaint IN000 due to lack of ev Unrelated deficiencies Survey dates: Market Marke	encies cited. ay 31 and June 1, 2011 000056 : 155131 00289450 N, TC		0000	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GS1I11

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/01/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
F0223 SS=D	findings cited in 16.2. Quality review of Cathy Emswiller. The resident has the verbal, sexual, physical punishment, or inverse grant of acility failed to a free from abuse of allegation of physical punishment, or inverse from abuse of allegations of about #D) Findings include The allegation of reviewed on 6/1/ of the Memorand facility indicated LPN #1 was seat	he right to be free from visical, and mental abuse, ent, and involuntary ot use verbal, mental, abuse, corporal voluntary seclusion. review and interview, the ensure every resident was related to a witnessed sical abuse for 1 of 3 use reviewed. (Resident	F0223	F-223 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission this response is not to be construed as an admission deficiency against the facility Administrator, or any employ who draft or may be discuss this response and Plan of Correction. In direct response the five questions listed on pone of Kim Rhoades, Direct Long Term Care, letter to this facility dated June 6, 2011, the facility offers the following: 1 What corrective action(s) we say that a submission of the five questions are considered.	of any y, the yees ed in se to bage or of s he

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155131	B. WIN			06/01/2	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	-	LSC IDENTIFYING INFORMATION)	+	IAU	be accomplished for those		DATE
		er. LPN #1 indicated the			residents found to have be	an l	
	resident was observed to be leaning				affected by the deficient	511	
	forward in her wheelchair, which had				practice? As it relates to the	۵ ـ	
	been typical for	this resident despite staff's			resident identified as Letter [
	attempts to repos	sition her. LPN #2 was			respectfully offer that immed		
	observed to appr	oach Resident #D from			upon receipt of the concern	of	
	1 **	hly pull her body forward			possible abuse, the facility		
	1	r and then roughly push			removed LPN#2 from the nu	rsing	
		eelchair forward up to the			unit and commenced an investigation. In accordance	with	
		LPN #1 indicated LPN #2			the Indiana State Departmer		
					Health guidelines for Reporta		
	1	y attempts to notify the			Occurrences and facility poli		
		ntended actions. LPN #1			and procedure, we reported	the	
	also indicated th	at CNA #1 was also			allegation of possible abuse.		
	sitting at the nur	se's station at that time,			Additionally, prior to surveyo		
	and witnessed th	e entire event.			citation, the facility submitted		
					final report indicating the out of our investigation and corre		
	Review of the w	itness statement provided			actions taken. LPN#2	Clive	
		1 5/20/11 indicated "At			subsequently resigned from	her	
	1 *	:30 p.m., I was sitting at			employment with our facility		
		n on the second floor.			was noted in the facility's fina	al	
					report. 2. How other reside	nts	
	`	me) was also sitting at the			having the potential to be		
		She was bent over in her			affected by the same defici		
		ch is not abnormal for her.			practice will be identified a		
	LPN #2, who wa	as assigned to the second			what corrective action(s) w be taken? Munster Med-Inn		
	floor unit walked	d up behind Resident #D			committed to investigating al		
	and using the res	sident's shoulder roughly			allegations of abuse and rep		
	pulled her up to	a sitting position in the			as such in accordance with t	-	
	1 ^	shoved the chair under the			Indiana State Department of		
		rrse's station and locked			Health and facility policy and		
		#2 angerly stated she			procedure. 3. What measur		
		• •			will be put into place or who		
	was sick and tire				systematic changes will be made to ensure that the		
	everyone's mess.				deficient practice does not		
					recur? We respectfully offer		
	Review of the w	itness statement provided			100a. 1 Tro respectivity offer		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	LETED
		155131	B. WIN			06/01/2	011
			B. WIN		ODRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			LUMET AVENUE		
MUNICTE	ER MED-INN			1	ER, IN46321		
MONSTE	EK MED-INN			INIONSTE	ER, 11140321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	by CNA #1 (no	date) indicated "I worked			the below noted corrective		
	the second floor unit on 3-11 shift on				actions were taken as a dire		
		ved Resident #D sitting at			result of our initial investigat		
		•			the time of the occurrence.		
		on. LPN #2 came up			response to the allegation of		
	1	ent, put her hand on her			abuse involving the Residen		
	chest and jerked	her to a sitting position.			the facility provided an in-se on June 1, 2011 to all staff of		
	She then shoved	her wheelchair under the			provision of care to cognitive		
	counter and lock	xed the brakes. LPN #2			impaired residents with a foo		
		he me to check to see if			on proper approach. As a fa		
					we are fully committed to	,	
		PN #2 was abrupt and			on-going in-service education	n and	
	"	dent #D. LPN #2 did not			present Resident Abuse and		
	have any conver	sation with the resident			Abuse Prevention topics on	а	
	prior to moving	her"			minimum of a quarterly basis	s. In	
	-				addition to our previously		
	Further review of	of the allegation of abuse			implemented corrective action	on,	
	1				the facility is committed to		
	1 -	receipt of the concern,			presenting a mandatory in-s		
	1	nediately removed from			on the topic of Possible Res		
	the facility pend	ing the initiation of the			Abuse/Reporting of Possible		
	investigation.				Abuse for all-staff through o on-going In-Service Education		
					Program. This in-service wi		
	 Interview with I	LPN #1 on 5/31/11 at 2:00			presented prior to July 1,	ii bc	
					2011. 4. How the corrective	re	
	1 -	she did witness the entire			action(s) will be monitored		
	1	ened on 5/20/11. She			ensure the deficient practic		
		2 came up from behind			will not recur, i.e., what qua		
	the resident, gra	b her and roughly pushed			assurance program will be	-	
	her back into the	e wheelchair. She also	1		into place? The facility has	-	
		N pushed her wheelchair			comprehensive Abuse Preve		
	1	g station counter and			Policy in place which is review		
		C			annually. We are committed		
	locked the brakes. LPN #1 indicated that she reported the incident to the Director of Nursing immediately.				reviewing our policies and m	naking	
					any necessary revisions or		
					updates as needed during th		
	1				annual review process or at		
	3.1-27(a)(1)				other time deemed appropri		
					addition, the facility offers that		
	<u> </u>				through our Quality Assurance	_	
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	GS1I11	Facility II	D: 000056 If continuation s	sheet Pa	ge 4 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155131	B. WING		06/01/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				ALUMET AVENUE	
	R MED-INN			TER, IN46321	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	ļ	2.112
				Program/Manager of The Week Focus Program, an audit of Abu	
				Protocols is completed. The au	
				performed on a quarterly basis a	
				requires that random sample of	•
				across all departments be interv	
				to ensure they are aware of the various types of abuse, how to be	•
				abuse, and to whom reports sho	
				be made. The findings from the	
				audits are compiled by facility	
				Administrator and reported to the	•
				Quality Assurance Committee of quarterly basis. 5. By what da	•
				the systematic changes wil	•
				completed? July 1, 2011	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155131	A. BUILDING	00	06/01/2011
		100101	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/01/2011
NAME OF F	PROVIDER OR SUPPLIER			ALUMET AVENUE	
	R MED-INN		I	ER, IN46321	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG			TAG	DEFICIENCT)	DATE
F0225 SS=D	have been found gor mistreating reside have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including in and misappropriating reported immediate the facility and to dwith State law throst (including to the Stagency).	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged g mistreatment, neglect, or any injuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all			
	alleged violations	are thoroughly investigated, further potential abuse while			
	The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.				
	facility failed to a allegation of abuse to the Administra	review and interview, the ensure every suspected se was reported promptly ator for 1 of 3 allegations d, as well as obtaining	F0225	F-225 Submission of this response and Plan of Correctis not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE references for 4 of 5 newly hired this response is not to be construed as an admission of any employees in a sample of 5 newly deficiency against the facility, the hired employees. (Resident #L, CNA Administrator, or any employees #2, CNA #3, CNA #4, and Laundry #1) who draft or may be discussed in this response and Plan of Correction. In direct response to Findings include: the five questions listed on page one of Kim Rhoades, Director of 1. Review of the Memorandum dated Long Term Care, letter to this 12/13/11 of an allegation of abuse towards facility dated June 6, 2011, the facility offers the following: 1. residents on the fifth floor indicated the What corrective action(s) will facility had received an anonymous letter be accomplished for those indicating the Unit Manager had been residents found to have been abusive toward some of the residents. affected by the deficient practice? The facility took a number of corrective actions as a Review of the anonymous letter dated result of our original investigation 11/19/10 received by the facility 11/30/10 into this matter. To recount those indicated the person writing the letter was corrective actions previously a concerned family member with family communicated in our final report dated December 13, 2010, the who resided on the fifth floor. The family facility conducted Stress member indicated they visit their loved Management and Abuse one several times a week and felt Prevention in-servicing to all obligated to inform the facility of the staff. This in-service covered the topic of stress management as things they had seen and heard from the well as the expectations of Unit Manager towards some of the reporting all possible abuse in a residents. The family member alleged the timely manner. As it relates to Unit Manager was rough with the C.N.A. #2, C.N.A. #3, C.N.A. #4, and Laundry #1, the facility has residents and pushed them down. On one completed reference checks and occasion they had seen her push a resident they are currently in place in the back down in their seat and say in a harsh identified staff member's voice, "sit your a** down." They had also personnel files. 2. How other heard her say to a resident she was residents having the potential to be affected by the same fu***** sick and tired of a resident who deficient practice will be was somewhat agitated and would be glad identified and what corrective when she shut the he** up. On another

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE occasion the family member had action(s) will be taken? As it relates to the resident identified witnessed a CNA trying to calm a resident as Resident L, the facility takes a down and was not successful. The Unit very strong position with regard to Manager indicated that she was going to timely reporting of possible give her something that would shut her abuse. The facility will, in the future, provide appropriate fu***** trap for the rest of her shift. corrective action (including discipline if deemed appropriate) Continued review of Memorandum dated for any staff member who does 12/13/11 indicated upon receipt of the not report possible abuse in a timely manner. In an effort to letter the Unit Manager was immediately offer additional corrective action removed from her position and was as a part of this plan of placed on administrative leave pending correction, the facility will present the outcome of the investigation. The follow-up in-servicing on the topic of Stress Management and facility was then able to speak personally Abuse Prevention in-servicing to to 26 family members. The facility all staff which will include indicated there was mostly positive requirements for timely reporting feedback, but one family member of possible abuse. As it relates to the completion of reference verbalized the Unit Manager had a bad checks for new employees, the attitude and she was described as being facility is committed to reviewing insensitive. The facility also spoke to 6 the personnel files of all newly professionals who routinely work with the hired staff in the past 120 days to verify the presence of a Unit Manager on the fifth floor. The completed reference check. Any facility indicated some of the staff felt that identified personnel files lacking a the Unit Manager was compassionate and reference check will have one others felt she was not. Some staff completed via telephone. 3. What measures will be put into indicated she had a "rough" way about place or what systematic her. Most staff felt the Unit Manager changes will be made to became frustrated easily and that caused a ensure that the deficient negative interaction with staff but not the practice does not recur? As it residents. All of the staff had indicated relates to the resident identified as Resident L, the facility will they had never seen the Unit Manager use continue to provide on-going profanity in front of the residents or was in-service education to all staff on physically abusive towards them. the policies for timely reporting of possible abuse. Through our

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE In-Service Education Program, on Review of LPN #3's statement dated a quarterly basis topics such as 12/1/10 regarding the Unit Manager from **Facility Abuse Prevention** the fifth floor indicated the LPN had Program, Resident Rights, worked three days a week and had the Managing Difficult Situations, Managing Employee Stress and occasion to work with the Unit Manager. Burn out, to name a few, are She indicated there had been occasions presented. The facility is when the Unit Manager had been committed to ensuring potentially abusive towards a resident. appropriate corrective action, in LPN #3 had observed poor interactions the future. for any staff member who fails to report possible abuse with Resident #L and that the Unit in a timely manner. Additionally, Manager had been forceful in making the facility offers that upon hire all Resident L sit down when standing. LPN new staff members are presented #3 had also observed the Unit Manager with a full copy of and complete a detailed review of the facility Abuse mock a resident who was crying by Prevention Program during their rubbing her own eyes and making crying General Orientation. During this noises and stating "there's nothing wrong review, the requirement to report with you, stop crying." LPN #3 has allegations of abuse immediately is witnessed the Unit Manager speak rudely discussed and staff members are made aware that failure to adhere to to family members. The LPN indicated facility Abuse Policies and the Unit Manager was bossy, Procedures may result in corrective disrespectful, and demeaning. action in the form of disciplinary action up to and including Interview with the Administrator on termination. The facility is committed to the on-going education 6/1/11 at 2:45 p.m., indicated she had of all staff and provide any additional interviewed the fifth floor nursing staff. Abuse Prevention in-servicing as She indicated that she was unaware of deemed necessary in conjunction LPN #3's allegations prior to the incident. with the topics already scheduled on She indicated LPN #3 should have a quarterly basis. Our in-services on this topic include the expectation that reported her allegations to the Director of possible abuse be reported Nursing or herself immediately after immediately as well as the witnessing those events. consequence for failure to report immediately which include 2. Review of the employee records on 6/1/11 corrective action in the form of indicated no pre-employment screening references disciplinary action up to and Facility ID:

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	00	COMPLETED
		155131	A. BUILDING		06/01/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				
			I	CALUMET AVENUE	
MUNSIE	R MED-INN		MUNS	TER, IN46321	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
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	had been obtained for	or CNA #2 hired 4/21/11, CNA		including termination. As it rel	ates
	#3 hired on 4/12/11.	, CNA #4 on 4/12/11, and		to the completion of reference	;e
	Laundry #1.			checks for new employees, t	he
				facility has modified it's exist	ing
	Interview with the A	Administrator on 6/1/11 at 3:40		policy on obtaining reference	;
	p.m., indicated that	no references had been		checks for all newly hired sta	•
	obtained for CNA#	2, CNA #3, CNA #4, and		We are committed to submit	
		rther indicated that this issue		all requests for reference ch	ecks
	had been identified	in Quality Assurance but no		to previous employers via	
	process had been de	eveloped to correct this issue.		fax/telephone and completin	-
				follow-up telephone calls to t	•
	At the exit interview	v on 6/1/11 at 4:45 p.m. with		employers if there has been	
		tor, Administrator, Assistant		response after 14 days. 4.	•
	Administrator, Dire	ctor of Nursing, and Assistant		the corrective action(s) will	De
		, it was indicated that no call		monitored to ensure the	
		reference after 30 days as per		deficient practice will not re	
	facility policy.			i.e., what quality assurance	
				program will be put into pla	ice?
	3.1-13(g)(1)			As it relates to the resident	
	3.1-28(c)			identified as Resident L, upon hire and subsequently theres	•
	3.1-28(d)			we will utilize our In-Service	arter,
	3.1 2 0(u)			Education Program as a tool	l to
				frequently remind our staff of	
				policies and procedures rela	
				to reporting of possible resid	
				abuse and will include the	
				consequences for failure to r	eport
				such possible abuse in a tim	•
				manner. As it relates to the	
				completion of reference che	•
				for new employees, through	the
				Human Resource Quality	
				Assurance Program, the fac	-
				Administrator/or Designee w	
				responsible for auditing a sa	· •
				of 100% of all newly hired st	ап то
				ensure the presence of a	
				reference check. The finding	- 1
				will be reported to the Qualit Assurance Committee on a	^y
				Assurance Committee on a	
				Į	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
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			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALUMET AVENUE		
MUNSTE	R MED-INN				ΓER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG			DATE
					quarterly basis. 5. By what o		
F0226 The facility must develop and implement					the systematic changes will be		
		avalan and implement			completed? July 1, 2011		
F0226	SS=D written policies and procedures that prohibit mistreatment, neglect, and abuse of residents						
35=D							
and misappropriation of resident property.							
	Based on record review and interview, the		F0	226	F-226 Submission of this		07/01/2011
		ensure the facility			response and Plan of Correc	tion	0,7,017,2011
					is not legal admission that a		
		e policy regarding			deficiency exists, or that a		
	reporting all alleg				Statement of Deficiency was		
	•	ne Administrator or			correctly cited. Submission of	of	
	Director of Nursi	ng for 1 of 3 allegations			this response is not to be	£	
	of abuse reviewe	d, as well as obtaining			construed as an admission o deficiency against the facility	,	
	references for 4	of 5 newly hired			Administrator, or any employ		
		sample of 5 newly			who draft or may be discusse		
		s. (Resident #L, CNA			this response and Plan of		
		A #4, and Laundry #1)			Correction. In direct response	e to	
	#2, CINA #3, CIN	A #4, and Laundry #1)			the five questions listed on page	-	
					one of Kim Rhoades, Directo		
	Findings include:				Long Term Care, letter to this		
					facility dated June 6, 2011, the		
	The current 5/18/	10 Incident Reporting			facility offers the following: 1. What corrective action(s) w		
	Policy provided b	by the Administrator			be accomplished for those	""	
	indicated "It is th	e policy and procedure			residents found to have bee	en	
		require all employees to			affected by the deficient		
	-	rences of potential			practice? The facility took a		
		y observe, hear about, or			number of corrective actions		
	-				result of our original investiga	ation	
	suspect to a super	ivisor or the			into this matter. To recount t		
	Administrator."				corrective actions previously		
					communicated in our final rep		
	Review of the cu	rrent 5/18/10 Reference			dated December 13, 2010, the facility conducted Stress	ie	
	Check policy ind	icated "It will be the			Management and Abuse		
		the hiring Department			Prevention in-servicing to all		
		p on any requests not			staff. This in-service covered	d the	
		hirty (30) days. If			topic of stress management		
	ictuilleu within th	mity (50) days. II					

li ´		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155131	B. WIN			06/01/2	011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	2		1	ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	-	Ference source my be			well as the expectations of reporting all possible abuse i	in a	
	contacted by telephone."				timely manner. As it relates t		
					C.N.A. #2, C.N.A. #3, C.N.A.		
	Review of the cu	rrent 5/18/10 Employee			and Laundry #1, the facility h		
	Screening Policy	provided by the			completed reference checks	and	
	Administrator, in	ndicated "Facility will			they are currently in place in	the	
	1	erence checks on all new			identified staff member's		
		erence should be from			personnel files. 2. How other		
					residents having the potent	tiai	
	1 ^	current employers. The			to be affected by the same deficient practice will be		
	policy and procedure for the reference checks in set forth in HRD-123. If no				identified and what correct	ive	
					action(s) will be taken? As		
	written response	, a call will be placed			relates to the resident identif		
	within 30 days."				as Resident L, the facility tak	es a	
					very strong position with rega	ard to	
	Review of the M	emorandum dated			timely reporting of possible		
	12/13/11 of an a	llegation of abuse towards			abuse. The facility will, in the	е	
		fifth floor indicated the			future, provide appropriate corrective action (including		
		ved an anonymous letter			discipline if deemed appropri	iate)	
	1	nit Manager had been			for any staff member who do		
	1	•			not report possible abuse in		
	abusive toward s	some of the residents.			timely manner. In an effort		
					offer additional corrective ac	tion	
		onymous letter dated			as a part of this plan of		
	11/19/10 receive	d by the facility 11/30/10			correction, the facility will pre		
	indicated the per	son writing the letter was			follow-up in-servicing on the of Stress Management and	tobic	
	a concerned fam	ily member with family			Abuse Prevention in-servicin	a to	
		he fifth floor. The family			all staff which will include	J	
		d they visit their loved			requirements for timely report	rting	
	1	s a week and felt			of possible abuse. As it relat	es to	
					the completion of reference		
	obligated to inform the facility of the things they had seen and heard from the Unit Manager towards some of the residents. The family member alleged the Unit Manager was rough with the				checks for new employees, t		
					facility is committed to review the personnel files of all new	-	
					hired staff in the past 120 da		
					verify the presence of a	,,,,,,,	
					completed reference check.	Any	
	residents and put	shed them down. On one			identified personnel files lack	king a	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE occasion they had seen her push a resident reference check will have one completed via telephone. 3. back down in their seat and say in a harsh What measures will be put into voice, "sit your a** down." They had also place or what systematic heard her say to a resident she was changes will be made to fu***** sick and tired of a resident who ensure that the deficient practice does not recur? As it was somewhat agitated and would be glad relates to the resident identified when she shut the he** up. On another as Resident L, the facility will occasion the family member had continue to provide on-going witnessed a CNA trying to calm a resident in-service education to all staff on down and was not successful. The Unit the policies for timely reporting of possible abuse. Through our Manager indicated that she was going to In-Service Education Program, on give her something that would shut her a quarterly basis topics such as fu***** trap for the rest of her shift. Facility Abuse Prevention Program, Resident Rights, Managing Difficult Situations, Continued review of Memorandum dated Managing Employee Stress and 12/13/11 indicated upon receipt of the Burn out, to name a few, are letter the Unit Manager was immediately presented. The facility is removed from her position and was committed to ensuring appropriate corrective action, in placed on administrative leave pending the future, for any staff member the outcome of the investigation. The who fails to report possible abuse facility was then able to speak personally in a timely manner. Additionally, to 26 family members. The facility the facility offers that upon hire all new staff members are presented indicated there was mostly positive with a full copy of and complete a feedback, but one family member detailed review of the facility Abuse verbalized the Unit Manager had a bad Prevention Program during their attitude and she was described as being General Orientation. During this insensitive. The facility also spoke to 6 review, the requirement to report allegations of abuse immediately is professionals who routinely work with the discussed and staff members are Unit Manager on the fifth floor. The made aware that failure to adhere to facility indicated some of the staff felt that facility Abuse Policies and the Unit Manager was compassionate and Procedures may result in corrective others felt she was not. Some staff action in the form of disciplinary action up to and including indicated she had a "rough" way about termination. The facility is her. Most staff felt the Unit Manager

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE became frustrated easily and that caused a committed to the on-going education of all staff and provide any additional negative interaction with staff but not the Abuse Prevention in-servicing as residents. All of the staff had indicated deemed necessary in conjunction they had never seen the Unit Manager use with the topics already scheduled on profanity in front of the residents or was a quarterly basis. Our in-services on this topic include the expectation that physically abusive towards them. possible abuse be reported immediately as well as the Review of LPN #3's statement dated consequence for failure to report 12/1/10 regarding the Unit Manager from immediately which include the fifth floor indicated the LPN had corrective action in the form of disciplinary action up to and worked three days a week and had the including termination. As it relates occasion to work with the Unit Manager. to the completion of reference She indicated there had been occasions checks for new employees, the when the Unit Manager had been facility has modified it's existing policy on obtaining reference potentially abusive towards a resident. checks for all newly hired staff. LPN #3 had observed poor interactions We are committed to submitting with Resident #L and that the Unit all requests for reference checks Manager had been forceful in making to previous employers via Resident L sit down when standing. LPN fax/telephone and completing follow-up telephone calls to those #3 had also observed the Unit Manager employers if there has been no mock a resident who was crying by response after 14 days. 4. How rubbing her own eyes and making crying the corrective action(s) will be noises and stating "there's nothing wrong monitored to ensure the with you, stop crying." LPN #3 has deficient practice will not recur, i.e., what quality assurance witnessed the Unit Manager speak rudely program will be put into place? to family members. The LPN indicated As it relates to the resident the Unit Manager was bossy, identified as Resident L, upon disrespectful, and demeaning. hire and subsequently thereafter, we will utilize our In-Service Education Program as a tool to Interview with the Administrator on frequently remind our staff of the 6/1/11 at 2:45 p.m., indicated she had policies and procedures relative interviewed the fifth floor nursing staff. to reporting of possible resident abuse and will include the She indicated that she was unaware of consequences for failure to report LPN #3's allegations prior to the incident.

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CON	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155131	A. BUILDIN	G	00	COMPL 06/01/2	
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NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
MUNSTE	R MED-INN				LUMET AVENUE ER, IN46321		
							77.0
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		N #3 should have			such possible abuse in a time	elv	
		gations to the Director of			manner. As it relates to the	,	
		If immediately after			completion of reference chec		
	witnessing those				for new employees, through	the	
	withessing those	events.			Human Resource Quality Assurance Program, the facility		
	2 Review of the	e employee records on			Administrator/or Designee wi		
		no pre-employment			responsible for auditing a sar	•	
		nces had been obtained			of 100% of all newly hired sta ensure the presence of a	ant to	
	_	d 4/21/11, CNA #3 hired			reference check. The finding	ıs İ	
		· ·			will be reported to the Quality		
	on 4/12/11, CNA #4 on 4/12/11, and Laundry #1.				Assurance Committee on a		
					quarterly basis. 5. By what of		
	Interview with th	ne Administrator on			the systematic changes will completed? July 1, 2011	De	
		n., indicated that no			completed: daily 1, 2011		
	-	een obtained for CNA #2,					
		4, and Laundry #1. She					
	=	that this issue had been					
		uality Assurance but no					
		developed to correct this					
	issue.	developed to correct this					
	13340.						
	At the exit interv	riew on 6/1/11 at 4:45					
	p.m. with the Ex						
	*	Assistant Administrator,					
	-	ing, and Assistant					
		ing, it was indicated that					
		e to obtain reference after					
	30 days as per fa						
	20 days as per it	somy poney.					
	3.1-28(a)						
	5.1 20(u)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must ensure that the resident F0323 environment remains as free of accident SS=D hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview. F0323 07/01/2011 F-323 the facility failed to supervisor resident for 1 of 1 resident reviewed for falls in a Submission of this response and sample of 11 related to staff being Plan of Correction is not legal unaware that during a fire pump test the admission that a deficiency exists, or that a Statement of doors are unlocked, staff not monitoring Deficiency was correctly cited. unlocked doors and resident going Submission of this response is through unlocked door and falling down not to be construed as an the stairs. (Resident #C) admission of any deficiency against the facility, the Administrator, or any employees Findings include: who draft or may be discussed in this response and Plan of The record for Resident #C was reviewed Correction. on 6/1/11 at 11:20 a.m. The resident's In direct response to the five diagnoses included, but was not limited questions listed on page one of to, dementia, hypertension, dysphasia, Kim Rhoades, Director of Long cerebrovascular accident (stroke), Term Care, letter to this facility dated June 6, 2011, the facility Parkinson's Disease, and anxiety. offers the following: A nursing note dated 12/1/10 at 5:00 p.m., What corrective indicate the resident was up in a action(s) will be accomplished for those residents found to wheelchair self propelling in hallway and have been affected by the into other resident's rooms. The resident deficient practice? was redirected with no success. The resident indicated she had the right to be With regard to the resident in that room. The resident tries the exit identified as Resident C, the facility immediately commenced doors when going up and down the halls. an investigation at the time of The resident was alert and verbally incident. Additionally, this matter responsive with confusion. At 7:05 p.m. was reported to the Indiana State the resident was at the nurse's station. At Department of Health in

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 06/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 7:50 p.m. Resident #M was observed accordance with Indiana State Department of Health guidelines looking through the window on the exit for Reportable Occurrences and door. Resident #M called to the nurse and facility policies and procedures. pointed down the hall. Resident #M led How other residents the nurse to the exit door and looked having the potential to be through the window. The nurse looked affected by the same deficient through the window and saw Resident #C practice will be identified and lying on her back, on the landing with half what corrective action(s) will of the wheelchair on the resident's body. be taken? Resident #C was alert, oriented, and As a result of this incident, the answered questions appropriately. facility reviewed and revised it's Resident #C was lying on her back with policies for monitoring all exits on head slightly off floor resting on the wall. the 5th floor unit during Fire There was blood no the landing and Pump Testing. All staff were in-serviced as part of our Resident #C's right arm was in between corrective action plan which was the spokes of the wheelchair. 911 was implemented at the time of the called. occurrence. It is the policy of this facility to notify 5th floor staff prior to scheduled Fire Pump Testing A nursing note dated 12/2/10 at 6:00 a.m., of plans to initiate such testing to indicated resident was admitted to the ensure that staff provide hospital for observation only. At 1:55 necessary monitoring of exits. p.m. the resident returned to the facility. This incident occurred nearly six months ago and our corrective The resident was alert, oriented and able action thus far, we feel, has been to move all extremities. The resident had successful. We are committed, an abrasion to her forehead measuring 1 however, to providing a remedial cm (centimeter) by 2 cm with a scab. in-service on this procedure to all staff as a part of this plan of There was a bruise noted to the resident's correction. forehead, purple in color and measuring 4 cm by 7 cm. The resident's right elbow What measures will be had a purple bruise measuring 8 cm by 4 put into place or what cm. She had edema to her right elbow. systematic changes will be made to ensure that the The resident did not complain of pain or deficient practice does not discomfort. recur?

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155131	B. WIN			06/01/201	1
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
NALINIOTE	TO MED ININ			1	ALUMET AVENUE		
MUNSTE	R MED-INN			MUNSI	ΓER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	ı	ated 12/3/10 at 3:00 p.m.,			In addition to the corrective		
	indicated a late entry for 12/2/10 at 1:55			actions initially taken in			
	_	nt had an abrasion with			December of 2010, the facilit	y will	
	scabs to her first,	second and third left			present in-servicing to all sta	I	
	finger knuckles.				the topic of monitoring of exit		
					the 5th floor during periods of disarmament of our magnetic	I	
	A Reportable Oc	currence was provided by			locking system (i.e., Schedul		
	the Administrator	r and the Assistant			Fire Pump Testing, schedule		
	Administrator an	d reviewed on 6/1/11 at			and non-scheduled fire drills	I	
	12:30 P.M. "On 12/1/10 at approximately 7:53 p.m., (Resident #C's name) was				etc.). The in-service will incl	ude	
					our policy that prior to any scheduled Fire Pump Testing	.	
	identified to be found on the landing of				being performed that the 5th		
		ell on the 5th floor.			nursing staff will be notified of		
		ame had fallen from her			plans to engage testing so th		
	`	ten (10) stairs and was			staff are aware of need for		
	noted to be bleed	` '			monitoring of exit.		
	noted to be breed	9.					
	Upon obtaining	statements and					
		cause of this unfortunate			4. How the corrective		
		as determined that			action(s) will be monitored	I .	
	· ·	54 p.m., a routine fire			ensure the deficient practic	I .	
		ommenced which disables			will not recur, i.e., what qua assurance program will be	- 1	
					into place?		
		nanisms on the stair well our safety procedures.			'		
	^	• •			In collaboration with the 5th f	I .	
	1	n determined doors were			Nursing Unit Director, the Bu		
		eriod of twelve (12)			Manager will be responsible the monitoring and evaluatio	I .	
		ras the duration of the fire			the response on 5th floor du		
		acility has contacted our			Fire Pump Testing to ensure		
		o confirm the times of			compliance with policy and		
		he locked doors and			procedure. The Building		
	confirmed this occurrence. It is probable that (Resident #C's) exited through the				Manager and/or 5th Floor Nu Unit Director shall report any		
					lapses in adherence with pol	I	
		uring this period of time			and procedure to facility	´	
	and fell."				Administration.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/01/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	discuss preventate future. During a facility has now to monitor all exunit during the wan additional preserview with thou 6/1/11 at 2:35 to running a fire announcement wintercom system announcement whowever it was the fire pump tes Wednesday. Stabeen completed as the test was ran Assistant Admin the staff on the during the doors were used and would know The staff working unaware the doors.	ne Assistant Administrator p.m., indicated that prior pump test an as made over the On 12/1/10 the as made prior to the test, he first time the test was 11 shift. She indicated t was ran weekly and on ff realized the test had not on 12/1/10 during the day an on the 3-11 shift. The distrator further indicated ay shift was aware that inlocked during this test to monitor the doors. In the doors are that the shocked and the that they needed to			5. By what date the systematic changes will be completed? July 1, 2011		